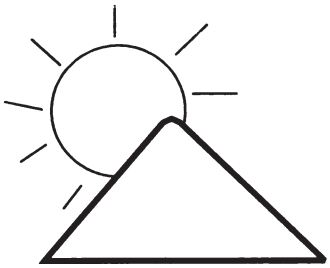
Summer Hill

REGISTRATION FORM
EXTENDED CARE PROGRAM
2017-2018



1107 Gully Road
Wall, New Jersey
07753
732-681-3483
Fax 732-681-3502
Web: summerhillschool.com

Home Phone _____

Name _____ D.O.B. _____ Grade _____
LAST FIRST NICKNAME DATE OF BIRTH

Street Address _____ Town _____ Zip _____

Emergency Number _____
NAME PHONE NUMBER

E-mail: _____

Father's Name _____ Occupation _____

Father's Work Phone _____ Cell Phone _____

Mother's Name _____ Occupation _____

Mother's Work Phone _____ Cell Phone _____

Siblings (names & ages) _____ Previous Schooling _____

E-mail: _____ Referred by _____

EXTENDED CARE PROGRAM:

Please circle the days attending **AM** extended care: M T W TH FR.

List below approximate **AM** drop off times: **7:45 – 8:45**

M_____ T_____ W_____ TH_____ FR_____

Please circle the days attending PM extended care: **M T W TH FR**

List below approximate **PM** pick up times: **3:30 – 5:30**

M_____ T_____ W_____TH_____ FR_____

RATE: $10 per hour/ per child; $8 per hour for any siblings
THE FIRST MONTH PAYMENT is DUE IN ADVANCE.
FEE ENCLOSED:_____

PLEASE READ CAREFULLY and SIGN

I wish to register my child for the extended care program at Summer Hill School. I understand the rate is $10 per hour/ per child and agree to make first payment in advance and monthly payments when due. **I understand there are no refunds for illness or vacations.** ***We close promptly at 5:30 pm daily, any students picked up after 5:30 will be charged a late fee of $1 per minute/per child.***

Signature:_____ Date:_____

Space is limited. To reserve a space for your child, please include payment with all necessary paperwork.

PLEASE MAKE SURE TO CONTACT WALL TRANSPORTATION AND FILL OUT A BABYSITTER FORM ASAP.

Emergency Information

Student _____ Home Phone _____

Physician _____ Physician Telephone _____

EMERGENCY NUMBERS (Please List Parents First)

1. Name _____ Relationship _____

Day Phone _____ Cell _____ Other _____

2. Name _____ Relationship _____

Day Phone _____ Cell _____ Other _____

3. Name _____ Relationship _____

Day Phone _____ Cell _____ Other _____

Serious Illness or Surgery _____

Physical Limitations _____

Allergies _____

Medications _____

Behavioral Issues/Concerns _____

CHILD'S INSURANCE

Company/HMO _____

Group Number _____ Identification # _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above child care center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency:
1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following.
    (a) Call for emergency first aid assistance/transportation.
    (b) Call another physician.
    (c) Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: _____ Date: _____